Pandemic—1

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THE MONSTER ENTERS

Coronavirus[1] is the old movie that we've been watching over and over again since Richard Preston's *The Hot Zone* (1994) introduced us to the exterminating demon, born in a mysterious bat cave in Central Africa, known as Ebola. It was the first in a succession of new diseases erupting in the 'virgin field' (that's the proper term) of humanity's inexperienced immune systems. Ebola was soon followed by avian influenza, which jumped to humans in 1997, and SARS, which emerged at the end of 2002; both initially appeared in Guangdong, the world's manufacturing hub. Hollywood, of course, lustfully embraced these outbreaks and produced a score of movies to titillate and scare us. (Steven Soderbergh's *Contagion*, released in 2011, stands out for its accurate science and eerie anticipation of the current chaos.) In addition to these films, and the innumerable lurid novels, hundreds of serious books and thousands of scientific articles have responded to each outbreak, many emphasizing the appalling state of global preparedness to detect and respond to such novel diseases.

I

So Corona walks through the front door as a familiar monster. Sequencing its genome (very similar to its well-studied sister SARS) was simple enough, yet the most vital bits of information are still missing. As researchers work night and day to characterize the virus, they are faced with three huge challenges. First, the continuing shortage of test kits, especially in the United States and Africa, has prevented accurate estimates of key parameters such as reproduction rate, size of infected

population and number of benign infections. The result has been a chaos of numbers. Second, like annual influenzas, the virus is mutating as it courses through populations with different age compositions and health conditions. The variety that Americans are most likely to get is already slightly different from that of the original outbreak in Wuhan. Further mutation could be benign, or it could alter the current distribution of virulence which now spikes sharply after age 50. Either way, Trump's 'corona flu' is at minimum a mortal danger to the quarter of Americans who are elderly, have weak immune systems or suffer from chronic-respiratory problems.

Third, even if the virus remains stable and little mutated, its impact on younger age cohorts could differ radically in poor countries and amongst high-poverty groups. Consider the global experience of the Spanish Flu in 1918–19, which is estimated to have killed 1 to 2 per cent of humanity. In the US and Western Europe, the original H1N1 in 1918 was most deadly to young adults. This has usually been linked to their relatively strong immune systems, which overreacted to the infection by attacking lung cells, leading to viral pneumonia and septic shock. More recently, however, some epidemiologists have theorized that older adults may have been protected by 'immune memory' from an earlier outbreak in the 1890s.

Spanish Flu found a favoured niche in army camps and battlefield trenches where it scythed down young soldiers by the tens of thousands. This became a major factor in the battle of empires. The collapse of the huge German spring offensive of 1918, and thus the outcome of the War, has been attributed to the fact that the Allies, in contrast to their enemy, could replenish their sick armies with newly arrived American troops. But the Spanish Flu in poorer countries had a different profile. It's rarely appreciated that almost 60 per cent of global mortality, perhaps 20 million deaths, occurred in the Punjab, Bombay and other parts of western India, where grain exports to Britain and brutal requisitioning practices coincided with a major drought. Resultant food shortages drove millions of poor people to the edge of starvation. They became victims of a sinister synergy between the flu and malnutrition, which suppressed their immune response to infection and produced rampant bacterial,

[1] There has been much confusion about scientific terminology: the International Committee on Taxonomy of Viruses has named the virus SARS-CoV-2, while COVID-19 designates the current outbreak. An earlier version of this article appeared on the *Jacobin* website, 14 March 2020; it has been expanded and updated for NLR.

as well as viral, pneumonia. In a similar case in British-occupied Iran, several years of drought, cholera and food shortages, followed by a widespread malaria outbreak, preconditioned the death of an estimated fifth of the population.

This history—especially the unknown consequences of interactions with malnutrition and existing infections—should warn us that COVID-19 might take a different and more deadly path in the dense, sickly slums of Africa and South Asia. With cases now appearing in Lagos, Kigali, Addis Ababa and Kinshasa, no one knows (and won't know for a long time because of the absence of testing) how it may synergize with local health conditions and diseases. Some have claimed that because the urban population of Africa is the world's youngest, with over-65s comprising only 3 per cent of the population—as opposed to 23 per cent in Italy—the pandemic will only have a mild impact. In light of the 1918 experience, this is a foolish extrapolation. As is the assumption that the pandemic, like seasonal flu, will recede with warmer weather.

More likely, as *Science* warned on 15 March, Africa is 'a ticking time-bomb'.[2] In addition to malnourishment, the fuel for such a viral explosion is the huge number of people with crippled immune systems. HIV/AIDS has killed 36 million Africans over the past generation, and researchers estimate that there are currently 24 million cases, along with at least 3 million suffering from the 'white plague', tuberculosis. Some 350 million Africans are chronically malnourished, and the number of small children whose growth has been stunted by hunger has been increasing by millions since 2000. Social distancing in mega-slums like Kibera in Kenya or Khayelitsha in South Africa is an obvious impossibility, while more than half of Africans lack access to clean water and basic sanitation. Additionally, five of the six nations with the world's worst healthcare are in Africa, including the most populous, Nigeria. Kenya, a country well-known for exporting nurses and doctors, has exactly 130 ICU beds and 200 certified ICU nurses to greet the arrival of COVID-19.

2

A year from now we may look back in admiration at China's success in containing the pandemic—and in horror at the US's failure. (I'm making

[2] Linda Nordling, '"A ticking time bomb": Scientists worry about coronavirus spread in Africa', *Science*, 15 March 2020.

the heroic assumption that China's declaration of rapidly declining transmission is more or less accurate.) The inability of US institutions to keep Pandora's Box closed is hardly a surprise. Since 2000 we've repeatedly seen breakdowns in frontline healthcare. Both the 2009 and 2018 flu seasons, for instance, overwhelmed hospitals across the country, exposing the drastic shortage of hospital beds after years of profit-driven cutbacks of in-patient capacity. The crisis dates back to the corporate offensive that brought Reagan to power and converted leading Democrats into neoliberal mouthpieces. According to the American Hospital Association, the number of in-patient hospital beds declined by an extraordinary 39 per cent between 1981 and 1999. The aim of this reduction was to raise profits by increasing 'census' (the number of occupied beds). But management's goal of 90 per cent occupancy meant that hospitals no longer had capacity to absorb patient influx during epidemics and medical emergencies.

In the new century, US emergency medicine continues to be downsized in the private sector by the 'shareholder-value' imperative of increasing short-term dividends and profits, and in the public sector by fiscal austerity and reductions in preparedness budgets. As a result, there are only 45,000 ICU beds available to deal with the projected flood of critical coronavirus cases. (By comparison, South Koreans have over three times more beds available per 1,000 people than Americans.) According to an investigation by *USA Today*, 'only eight states would have enough hospital beds to treat the 1 million Americans of 60 and over who could become ill with COVID-19'. At the same time, Republicans have repulsed all efforts to rebuild safety nets shredded by the 2008 recession budget cuts. Local and state health departments—the vital first line of defence—have 25 per cent fewer staff today than they did before Black Monday twelve years ago. Over the last decade, the CDC's budget has fallen 10 per cent in real terms.[3] Since the coronation of Trump, fiscal shortfalls have only been exacerbated. The *New York Times* recently reported that 21 per cent of local health departments reported reductions in budgets for the 2017 fiscal year.

Trump also closed the White House pandemic office, a directorate established by Obama after the 2014 Ebola outbreak to ensure a rapid and

[3] CDC: Centers for Disease Control and Prevention, under the Department of Health.

well-coordinated national response to new epidemics, and three months before the outbreak he shut down the PREDICT project, a pandemic early-warning system and foreign-aid programme established after the avian flu crisis in 2005. According to *Science*, PREDICT had 'discovered more than 1,000 viruses from viral families that contain zoonoses, including viruses involved in recent outbreaks, and others of ongoing public health concern.' This total included 160 potentially dangerous coronaviruses identified in bats and other animals.

We are therefore in the early stages of a medical Katrina. Having disinvested in emergency-medical preparedness while all expert opinion recommended a major expansion of capacity, the US now lacks elementary supplies as well as public-health workers and emergency beds. National and regional stockpiles have been maintained at levels far below what is indicated by epidemic models. Thus the test-kit debacle has coincided with a critical shortage of basic protective equipment for health workers. Militant nurses, our national social conscience, are making sure that we all understand the grave dangers created by inadequate stockpiles of protective supplies like N95 face masks. They also remind us that hospitals have become greenhouses for antibiotic-resistant superbugs such as *C. difficile*, which may become major secondary killers in overcrowded hospital wards.

3

The outbreak has instantly exposed the stark class divide in healthcare that Our Revolution—the grassroots campaign group spun out of Bernie Sanders's 2016 election bid—has put on the national agenda. In sum, those with good health plans who can also work from home will be protected, assuming they follow the necessary safeguards. Public employees and other unionized workers with decent coverage will have to make difficult choices between their income and their health. Meanwhile, millions of low-wage service workers, farm employees, the unemployed and the homeless will be thrown to the wolves. As we all know, universal coverage in any meaningful sense requires universal provision for paid sick days. Some 45 per cent of the US workforce is currently denied that right—and therefore compelled to transmit the infection or set an empty plate. Likewise, fourteen Republican states

have refused to enact the provision of the Affordable Care Act that expands Medicaid to the working poor. That's why one in four Texans, for example, lacks coverage and has only the emergency room at the county hospital to seek treatment.

With Sanders as usual leading the charge, the Democrats successfully pressured the White House and congressional Republicans to agree to paid sick leave as an emergency measure. But, as Sanders immediately pointed out, the compromise legislation remains full of unacknowledged loopholes and can be rescinded as soon as the pandemic recedes. Nonetheless, it is an important beachhead for taking the struggle to the next level—permanent, universal sick days for the entire workforce. And as the Trump Administration, panicked by the prospect of electoral annihilation, concedes to other sensible measures, such as government control over production of key medical supplies, new opportunities arise for pressing the case for public medicine in months to come.

The deadly contradictions of private healthcare in a time of plague are most visible in the for-profit nursing-home industry which warehouses 2.5 million elderly Americans, most of them on Medicare. It is a highly competitive sector capitalized on low wages, understaffing and illegal cost-cutting. Tens of thousands die every year from the facilities' neglect of basic infection-control procedures and from state governments' failure to hold management accountable for what can only be described as manslaughter. For many care homes—particularly in Southern states—it is cheaper to pay fines for sanitary violations than to hire additional staff and provide them with proper training. It's not surprising that the first epicentre of community transmission was the Life Care Center, a nursing home in the Seattle suburb of Kirkland. I spoke to Jim Straub, an old friend and union organizer in Seattle-area nursing homes, who characterized the facility as 'one of the worst staffed in the state' and the broader Washington nursing-home system as 'the most underfunded in the country—an absurd oasis of austere suffering in a sea of tech money'.

Moreover, he pointed out that public-health officials were ignoring the crucial factor that explained the rapid transmission of the disease from the Life Care Center to ten other nearby nursing homes: 'Nursing home workers in the priciest rental market in America universally work multiple jobs, usually at multiple nursing homes'. The authorities failed to

find out the names and locations of these second jobs and thus lost all control over the spread of COVID-19. No one is yet proposing to compensate exposed workers for staying at home. Across the country, dozens, probably hundreds more nursing homes will become coronavirus hotspots. Many employees will eventually choose the food bank over such conditions and refuse to go to work. At which point the system could collapse, and we shouldn't expect the National Guard to empty bedpans.

4

The pandemic broadcasts the case for universal coverage and paid leave with every step of its deadly advance. While Biden chips away at Trump, progressives must unite—as Bernie proposes—to win the Democratic Convention for Medicare for All. This will be the task of the combined Sanders and Warren delegates inside Milwaukee's Fiserv Forum in mid-July, but the rest of us have an equally important role to play on the streets, starting with the fight against evictions, layoffs, and employers who refuse compensation to workers on leave. (Afraid of contagion? Stand six feet from the next protestor, and it will only make a more powerful image on TV.) Universal coverage and associated demands are only a first step, however. It's disappointing that in the primary debates, neither Sanders nor Warren highlighted Big Pharma's abdication of the research and development of new antibiotics and antivirals. Of the eighteen largest pharmaceutical companies, fifteen have totally abandoned the field. Heart medicines, addictive tranquilizers and treatments for male impotence are profit leaders, not the defences against hospital infections, emergent diseases and traditional tropical killers. A universal vaccine for influenza—that is to say, a vaccine that targets the immutable parts of the virus's surface proteins—has been a possibility for decades, but never profitable enough to be a priority.

As the antibiotic revolution is rolled back, old diseases will reappear alongside novel infections, and hospitals will become charnel houses. Even Trump can opportunistically rail against absurd prescription costs, but to combat this scenario we need a programme to break up drug monopolies and provide for the public production of lifeline medicines. (This used to be the case: during WWII the US Army enlisted Jonas Salk and other researchers to develop the first flu vaccine.) As I wrote fifteen years ago in *The Monster at Our Door*:

> Access to lifeline medicines, including vaccines, antibiotics and antivirals, should be a human right, universally available at no cost. If markets can't provide incentives to cheaply produce such drugs, then governments and non-profits should take responsibility for their manufacture and distribution . . . The survival of the poor must at all times be accounted a higher priority than the profits of Big Pharma.

The current pandemic expands the argument: capitalist globalization now appears to be biologically unsustainable in the absence of a truly international public-health infrastructure. But such an infrastructure will never exist until social movements break the power of Big Pharma and for-profit healthcare. This requires an independent socialist design for human survival that goes beyond an updated New Deal. Since the days of Occupy, socialists have put the struggle against income and wealth inequality on Page One: a great achievement to be sure. But now we must take the next step of advocating social ownership and the democratization of economic power, with the healthcare and pharmaceutical industries as immediate targets.

The left must also make an honest evaluation of our political and moral weaknesses. As excited as I have been about the leftward evolution of a new generation and the return of the word 'socialism' to political discourse, there's a disturbing element of national solipsism in the US progressive movement that is symmetrical with the new nationalism. We tend to talk only about the American working class and American radical history (perhaps forgetting that Debs was an internationalist to the core), in what sometimes veers close to a left version of America Firstism. In addressing the pandemic, then, socialists should stress the urgency of international solidarism at every possible occasion. Concretely, we need to agitate our progressive friends and their political idols to demand a massive scaling up of the production of test kits, protective supplies and lifeline drugs for free distribution to poor countries. It's up to us to ensure that Medicare for All becomes foreign as well as domestic policy.

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